KAMALA D. HARRIS
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General
JUDITH J. LOACH
Deputy Attorney General
State Bar No. 162030
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5604
Facsimile: (415) 703-5480
E-mail: Judith.Loach@doj.ca.gov
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **AUDREY JOY KEENAN** **1480 Lemos Lane** **Fremont, CA 94539** **Registered Nurse License No. 627928** Respondent.	Case No. 2013-846 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 14, 2003, the Board of Registered Nursing issued Registered Nurse License Number 627928 to Audrey Joy Keenan ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 118, subdivision (b) of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

RELEVANT DISCIPLINARY STATUTES AND REGULATIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . ."

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

///

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

STATEMENT OF FACTS

10. Respondent at relevant dates was employed as a labor and delivery nurse at Washington Hospital HealthCare System ("WHHS"), Fremont, California.

11. At approximately 4:40 a.m., on May 27, 2010, Patient 1 was admitted to WHHS in active labor with a term pregnancy. Patient 1's primary nurse on admission was Arlene Relloma ("Relloma"), who at 5:05 a.m., telephoned Patient 1's primary physician and reported that the "FHR on admission 140's, but at 115 at this time, no accels (accelerations) noted, tracing at this point can't be confirmed as decel (deceleration) or change in baseline as baseline is not yet established; with minimal to moderate variability."[1] Dr. A.M. denied that nurse Relloma had informed her of concerns with the FHR tracing. Admission orders included continuous FHR monitoring and an epidural for pain relief.

12. From 5:14 a.m., to 6:04 a.m., Relloma took her break and Respondent assumed care of Patient 1. Relloma made no mention to Respondent of the FHR tracing.

13. The last recorded FHR of Patient 1's fetus was at 5:29 a.m., which reflected a heart rate between 100 to 110 beats per minute, with minimal variability and late decelerations.

14. At 5:30 a.m., the anesthesiologist was in Patient 1's room, with placement of the epidural completed at 5:53 a.m.[2] Respondent was at the nursing station during this time and was

[1] Pursuant to WHHS protocols, a reassuring tracing is one where the FHR baseline is between 110 to 160 beats per minute; there is moderate variability; the presence of accelerations and no decelerations. If the FHR tracing does not meet these requirements, then nursing interventions are to be taken and/or as necessary the patient's physician is to be notified.

[2] WHHS protocols required that there be continuous fetal heart rate monitoring when a (continued...)

aware that the FHR tracing demonstrated a fetal bradycardia and/or that the FHR signal was lost. Respondent acknowledged (silenced) the alarms at the monitor in the nursing station and did not go into Patient 1's room to assess her fetus.

15. At approximately 6:00 a.m. Respondent went into Patient 1's room in an attempt to locate the FHR. Respondent at 6:04 a.m., applied a fetal scalp electrode ("FSE") in an attempt to pick up the FHR. [3] Relloma had returned from her break and at 6:07 a.m., and she removed the FSE and attempted to locate the FHR by adjustment of the external monitor. A second FSE was placed by Relloma at 6:12 a.m. No fetal heart rate was detected. The charge nurse arrived in the room at 6:14 a.m., and applied a third FSE and instructed Respondent to call Patient 1's physician.

16. At approximately 6:15 a.m., Dr. A.M. was called at home and advised that the nursing staff was unable to find the FHR on Patient 1. The in-house hospitalist, Dr. R.F. arrived in Patient 1's room at 6:17 a.m. A bedside abdominal ultrasound examination showed no fetal heart activity with the diagnosis of an intrapartum fetal demise.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Provide Continuous FHR Monitoring)

17. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that she failed to ensure, or even attempt to ensure that there was continuous FHR monitoring before and during the epidural procedure. The facts in support of this cause for discipline are set forth above in paragraphs 11 through 15.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence-Failure to Interpret FHR Tracing)

18. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1) in that she failed to interpret the FHR tracing during the time that she assumed care of

---

patient is receiving an epidural.

[3] A fetal scalp electrode is a method of directly monitoring the FHR by attaching an electrode to the fetal scalp.

Patient 1. The facts in support of this cause for discipline are set forth above in paragraphs 11 thorough 14.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence-Failure to Intervene)

19. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1) in that she failed to intervene when she knew and/or should have known that Patient 1's fetus had an abnormal FHR tracing. The facts in support of this cause for discipline are set forth above in paragraphs 13 and 14.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 627928, issued to Audrey Joy Keenan;

2. Ordering Audrey Joy Keenan to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: March 28, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2013403806